TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
PROPERTY & CASUALTY INS CO OF HARTFORD

MFDR Tracking Number
M4-15-2111-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MARCH 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an approved case with all other claims being paid in full."

Amount in Dispute: $1,022.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As explained by the attached EOBs, Hartford's denial of payment is consistent with Texas Workers' Compensation Act and Division Rules and Guidelines. Further, as explained by Hartford, a number of the services were not medically necessary and preauthorization was not obtained. Further, the Division lacks jurisdiction to consider any dates of service that occurred more than a year before medical dispute resolution was requested."

Response Submitted By: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2014 April 22, 2014	CPT Code 99214-25 Office Visit	$165.84/ea	$0.00
March 6, 2014	CPT Code 99080-73 Work Status Report	$15.00	$0.00
March 14, 2014 April 18, 2014 May 23, 2014	CPT Code 99361-W1 Case Management Services	$113.00/ea	$0.00
April 16, 2014 May 15, 2014 June 17, 2014	CPT Code 99213-25 Office Visit	$112.33/ea	$0.00
TOTAL		$1,022.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - OA-The amount adjusted is due to bundling or unbundling of services.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247-A payment or denial has already been recommended for this service.
   - 50-These are non-covered services because this is not deemed a medical necessity by the payer.
   - 56-Significant, separately identifiable E/M service rendered.
   - 197-Payment denied/reduced for absence of precertification/authorization.

Issues

1. Does a timely filling issue exist in this dispute?
2. Does a medical necessity issue exist in this dispute?
3. Are the disputed services eligible for medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are March 6, 2014 through June 17, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on March 12, 2015. This date is later than one year after the March 6, 2014 date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for date of service March 6, 2014.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed services rendered from March 14, 2014 through June 17, 2014 based upon "50-These are non-covered services because this is not deemed a medical necessity by the payer."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor

Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) states "the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General)." The appropriate dispute process for unresolved issues of medical necessity is pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that a medical necessity issue exists, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.

3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that the disputed services are eligible for medical fee dispute resolution. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/10/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.